END STAGE RENAL DISEASE PROGRAM

Confidential Financial Statement

APPLICANT'S INFORMATION

Name _____
Last First MI

Address _____
Number/Street/Apt. City State ZIP Code

Birth Date _____Gender: Male / Female

Telephone Number ( ) _____

Number of persons in household _____

Relationship to applicant _____

APPLICANT'S PERSONAL INCOME	**SPOUSE OR OTHER HOUSEHOLD MEMBERS'S INCOME**
Employer / Occupation _____	Employer / Occupation _____
City/State _____	City/State_____
Gross Earnings from Employer $_____	Gross Earnings from Employer $_____
Monthly Social Security $_____	Monthly Social Security $_____
Monthly Retirement Income $_____	Monthly Retirement Income $_____
Monthly Disability Income and Source $_____ _____	Monthly Disability Income and Source $_____ _____
Monthly Income any other Source $_____	Monthly Income any other Source $_____
Total Gross Income Last Year $_____	**Total Gross Income Last Year $**_____
➔ **Attach a Filed Copy of your most recent Income Tax Return. If you did not file a tax return, please send a letter of explanation along with all documentation of all income.**	➔ **Attach a Filed Copy of your most recent Income Tax Return. If you did not file a tax return, please send a letter of explanation along with all documentation of all income.**

BUSINESS, FARM, OR OTHER INCOME	**Amount $**
Yearly Farm or business Income (if listed, please attach an itemized statement of business income and expenditures).	
Yearly Income from any sources other than shown above (rental property you own, dividends, welfare, unemployment compensation, per capita payments, part - time, second jobs, child support, etc.).	

FINANCIAL DATA
Monthly Medical Expenses

Medical Insurance Information - Applicant Only

Company	Policy Holder	Policy #	Monthly Premium *

***[If the medical insurance premium covers both applicant and spouse and/or children put applicant's share only of the premium in the Monthly Premium box.]**

Expense	Monthly Amount
Housing (monthly payment) rent own	

Applicant's Medical Payments (please include documentation)

	Monthly Payment	Balance Owed
Physician		
Hospital		
Dental		
Prescriptions		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		

Assets (Applicant and Spouse)

Estimated Market Value of Home	
Value of Other Real Estate	
Stocks and/or bonds (name and value)	
Name of Bank	
Amount in Savings	
Amount in Checking	
Farm or business equipment value	
Other Assets (Type and Value)	

I (Applicant)_____ am applying for assistance from the End Stage Renal Disease Program, Department of Health. I am unable to pay for the recommended treatment. I will apply any hospital and or medical insurance and Medicare and/or Medicaid benefits I receive to the cost of my care. I will pay Medicare and/or Medicaid and other insurance premiums to provide coverage. I understand that the End Stage Renal Disease Program must give prior authorization for any care for which it is to pay.

All information I have given on this confidential financial statement and application is true to the best of my knowledge.

Signed_____Date_____

STATE OF WYOMING, DEPARTMENT OF HEALTH, RURAL AND FRONTIER HEALTH DIVISION
END STAGE RENAL DISEASE PROGRAM
6101 Yellowstone Road, Suite 510, Cheyenne Wyoming 82002
Office: (307)777-3527

Authorization to Furnish Information

Patients Name _____

Date of Birth _____

The information you have provided will remain confidential with the Department of Health**, EXCEPT** in the following circumstances:

The End Stage Renal Disease Program (ESRD) as part of the Department of Health is a covered entity. ESRD may request from any state agency, insurer, group health plan, health maintenance organization or similar entity any or all of your protected health information. This information includes the recipient's name, social security number, amount of payment, charge for services, date of services, and services rendered related to medical payment. This information may be used or disclosed for the process of treatment, payment or healthcare operations. This is in accordance with the Health Information Portability and Accountability Act section 164.502(a)(1)(ii). Please see your Client Privacy Rights Policy for use and disclosure of your protected health information.

I hereby authorize the release of information limited to payment information (as described above) to state agencies, insurers, group health/dental plans, third party administrators, health maintenance organizations or similar entities for the purpose set forth above**.**

End Stage Renal Disease Program provides financial assistance in payment of medical bills and prescriptions for those who have the diagnosis of End Stage Renal Disease. For those individuals that have had a kidney transplant the program only covers immunosuppressant medication.

By signing this consent, I give my permission to medical health care providers, hospitals, and free standing Dialysis Centers to release confidential medical information.

A photo copy or reproduction of this authorization is as valid as the original.

Signature_____ Date_____

Signature of Witness_____ Date_____